

# IL Dept. of Healthcare and Family Services

## Illinois Medical Assistance Program

### Provider Enrollment Application

(Must be Typed)

All fields must be completed or the application may be returned. If a field is Non-Applicable, the applicant should type N/A.

#### SECTION A: PROVIDER:

1. New Enrollment	<input type="checkbox"/>	Re-Enrollment	<input type="checkbox"/>	Name Change	<input type="checkbox"/>	Reinstatement Request	<input type="checkbox"/>	2. Provider Type	<input type="text"/>
3. Provider Name	<input type="text"/>								
4. Primary Office Address Street	<input type="text"/>								
5. City	<input type="text"/>				6. County	<input type="text"/>			
7. State	<input type="text"/>	8. Zip	<input type="text"/>	9. Telephone #	( ) -	10. Fax	( ) -		
11. Email Address (3)	<input type="text"/>			<input type="text"/>			<input type="text"/>		
12. SSN	<input type="text"/>	13. FEIN	<input type="text"/>	14. IBT#	<input type="text"/>	15. License/Certification #	<input type="text"/>		
16. DEA#	<input type="text"/>	17. Natl Prov ID#	<input type="text"/>	18. Medicare Part A#	<input type="text"/>	19. Organization Type	<input type="text"/>		
20. Control of Facility	<input type="text"/>	21. Fiscal Yr.	<input type="text"/>	22. CLIA #	<input type="text"/>	<input type="text"/>			

#### SECTION B: SERVICE/SPECIALTY:

23. Category of Service(s)	<input type="text"/>									
24. Provider Specialty: Primary Specialty	<input type="text"/>	Secondary Specialties	<input type="text"/>							
25. Physician UPIN No.	<input type="text"/>	26. OBRA Qualification (Physicians Only)	<input type="text"/>							
27. Hospital Admitting Privileges (Physicians Only)										
Hospital Name		<input type="text"/>	Address		<input type="text"/>					
Hospital Name		<input type="text"/>	Address		<input type="text"/>					
28. Pharmacy Location	<input type="text"/>	29. Pharmacist In-Charge	<input type="text"/>	30. License #	<input type="text"/>					
31. Electronic Billing? Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	32. If Yes, Pharmacy Software Vendor Name	<input type="text"/>	33. Pharmacy NCD/CP#	<input type="text"/>			
34. Transportation: Taxi Base/Meter/Flag Rate	<input type="text"/>	35. Taxi Mileage Rate	<input type="text"/>	36. Medicare: Hydraulic Manual Lift or Ramp	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
37. Long Term Care Medicare Bed Capacity	<input type="text"/>	38. Long Term Care Medicare Fiscal Intermediary	<input type="text"/>							
39. Long Term Care Building ID Code	<input type="text"/>									

**SECTION C: FORMER PARTICIPATION:**

40. Change of Ownership

Yes

☐

No

☐

Effective Date

41. Former Provider Number

Former Provider Name

**SECTION D: ADDITIONAL PARTICIPATION**

42. Provider Type

43. Provider Number

44. Provider Name

**SECTION E: PAYEE INFORMATION:**

45. Name

46. Telephone#

47. D/B/A

48. Street Address

49. City

50. State

51. Zip

52. SSN/FEIN

53. TIN Type Code

54. Medicare Part B#:

55. PIN

56. DMERC #

Name:

Telephone # ( ) -

D/B/A:

Street Address:

City

State

Zip

SSN/FEIN

TIN Type Code

Medicare Part B #:

PIN

DMERC #

**SECTION F: CERTIFICATION/SIGNATURE:**

I understand that knowingly falsifying or willfully withholding information may be cause for termination of participation in the Medical Assistance Program.

Under penalties of perjury, I hereby certify that all of the information provided in this application process is true, correct and complete and that the enrolling provider is in compliance with all applicable federal and state laws and regulations. I further certify that neither I, nor any of the following provider's employees, partners, officers, or shareholders owning at least five percent (5%) of said provider are currently barred, suspended, terminated, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from participation in the Medicaid or Medicare programs, nor are any of the above currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations. I further certify that none of the above are currently sanctioned by any federal agency for any reason. I authorize the Department of Healthcare and Family Services to verify the information provided on this application with other state and federal agencies.

Check this box if you want  
a provider handbook

☐

Signature:

Date:

Printed name of person signing above: